		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Springs Road (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

IDPA ID Number: 363835751001

Date of Initial License for Current Owners: 07/31/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,402	8,458	6,138	32,998	8
9	SNF/PED					9
10	ICF	4,115	1,304	96	5,515	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,517	9,762	6,234	38,513	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.80%

D. How many bed-hold days during this year were paid by Public Aid?
85 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/31/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 5,673

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	227,933	17,647	8,149	253,729		253,729		253,729			1
2	Food Purchase		156,568		156,568		156,568	(7,653)	148,915			2
3	Housekeeping	178,751	18,833		197,584		197,584	190	197,774			3
4	Laundry	35,366	11,506		46,872		46,872	(10,450)	36,422			4
5	Heat and Other Utilities			131,741	131,741		131,741	1,903	133,644			5
6	Maintenance	40,251		95,813	136,064		136,064	1,449	137,513			6
7	Other (specify):*											7
8	**TOTAL General Services**	482,301	204,554	235,703	922,558		922,558	(14,561)	907,997			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,891,333	97,983	11,094	2,000,410		2,000,410		2,000,410			10
10a	Therapy			459,495	459,495		459,495		459,495			10a
11	Activities	166,279	10,455	3,618	180,352		180,352		180,352			11
12	Social Services	30,087		2,185	32,272		32,272		32,272			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,087,699	108,438	494,392	2,690,529		2,690,529		2,690,529			16
	C. General Administration											
17	Administrative	142,629		254,341	396,970		396,970	(254,341)	142,629			17
18	Directors Fees											18
19	Professional Services			38,450	38,450		38,450	5,241	43,691			19
20	Dues, Fees, Subscriptions & Promotions			11,437	11,437		11,437	(109)	11,328			20
21	Clerical & General Office Expenses	352,079	25,339	15,754	393,172		393,172	11,606	404,778			21
22	Employee Benefits & Payroll Taxes			445,637	445,637		445,637	41,023	486,660			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,672	3,672		3,672	1,444	5,116			24
25	Other Admin. Staff Transportation							4,770	4,770			25
26	Insurance-Prop.Liab.Malpractice			108,771	108,771		108,771	1,868	110,639			26
27	Other (specify):*											27
28	**TOTAL General Administration**	494,708	25,339	878,062	1,398,109		1,398,109	(188,498)	1,209,611			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,064,708	338,331	1,608,157	5,011,196		5,011,196	(203,059)	4,808,137			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of LaGrange #0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			39,367	39,367		39,367	92,227	131,594			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,281	5,281		5,281	178,807	184,088			32
33	Real Estate Taxes							175,610	175,610			33
34	Rent-Facility & Grounds			767,510	767,510		767,510	(767,510)				34
35	Rent-Equipment & Vehicles			3,470	3,470		3,470	2,071	5,541			35
36	Other (specify):*											36
37	**TOTAL Ownership**			815,628	815,628		815,628	(318,795)	496,833			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,407		146,407		146,407		146,407			39
40	Barber and Beauty Shops			20,534	20,534		20,534		20,534			40
41	Coffee and Gift Shops			3,830	3,830		3,830		3,830			41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):* Nonallowable Costs			27,593	27,593		27,593	(27,593)				43
44	**TOTAL Special Cost Centers**		146,407	111,634	258,041		258,041	(27,593)	230,448			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,064,708	484,738	2,535,419	6,084,865		6,084,865	(549,447)	5,535,418			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,450)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(104)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,052)	43		13
14	Non-Care Related Interest	(123)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,154)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,647)	43		24
25	Fund Raising, Advertising and Promotional	(7,572)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule A	(7,227)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,347)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(510,100)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (510,100)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (549,447)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lagrange
Provider # 0038083
1/1/03 - 12/31/03

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(186)	19
Nonallowable Chamber of Commerce dues	(525)	20
Miscellaneous income offset	(300)	21
Deferred maintenance amort.	238	6
Disallow radiology	(3,722)	43
Disallow laboratory	(2,446)	43
Disallow out of period legal fees	(286)	19
Total	(7,227)	

See Accountants' Compilation Report

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18)	0	0	0	0	0	0	0	0	0	0	(18)	2
3	Housekeeping	0	0	190	0	0	0	0	0	0	0	0	190	3
4	Laundry	(10,450)	0	0	0	0	0	0	0	0	0	0	(10,450)	4
5	Heat and Other Utilities	0	0	1,903	0	0	0	0	0	0	0	0	1,903	5
6	Maintenance	0	0	1,211	0	0	0	0	0	0	0	0	1,211	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,468)	0	3,304	0	0	0	0	0	0	0	0	(7,164)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(254,341)	0	0	0	0	0	0	0	(254,341)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,232	5,645	0	0	0	0	0	0	0	0	12,877	19
20	Fees, Subscriptions & Promotions	0	0	416	0	0	0	0	0	0	0	0	416	20
21	Clerical & General Office Expenses	0	110	11,796	0	0	0	0	0	0	0	0	11,906	21
22	Employee Benefits & Payroll Taxes	0	0	33,388	0	0	0	0	0	0	0	0	33,388	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,444	0	0	0	0	0	0	0	0	1,444	24
25	Other Admin. Staff Transportation	0	0	0	4,770	0	0	0	0	0	0	0	4,770	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,868	0	0	0	0	0	0	0	1,868	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	7,342	52,689	(247,703)	0	0	0	0	0	0	0	(187,672)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,468)	7,342	55,993	(247,703)	0	0	0	0	0	0	0	(194,836)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	76,659	0	15,568	0	0	0	0	0	0	0	92,227	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(227)	178,860	0	174	0	0	0	0	0	0	0	178,807	32
33	Real Estate Taxes	0	167,510	0	936	0	0	0	0	0	0	0	168,446	33
34	Rent-Facility & Grounds	0	(767,510)	0	0	0	0	0	0	0	0	0	(767,510)	34
35	Rent-Equipment & Vehicles	0	0	0	2,071	0	0	0	0	0	0	0	2,071	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(227)	(344,481)	0	18,749	0	0	0	0	0	0	0	(325,959)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(21,425)	0	0	0	0	0	0	0	0	0	0	(21,425)	43
44	**TOTAL Special Cost Centers**	(21,425)	0	0	0	0	0	0	0	0	0	0	(21,425)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,120)	(337,139)	55,993	(228,954)	0	0	0	0	0	0	0	(542,220)	45

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of LaGrange		
				Limited Partnership	LaGrange	Real Estate ptsp.
See attached Schedule B		See attached Schedule B		Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, LLC	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 767,510	Sambell of LaGrange Limited Partnership	**	$	$ (767,510)	1
2	V	19	Professional fees		Sambell of LaGrange Limited Partnership	**	7,232	7,232	2
3	V	21	Bank charges		Sambell of LaGrange Limited Partnership	**	110	110	3
4	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	76,659	76,659	4
5	V	32	Interest expense		Sambell of LaGrange Limited Partnership	**	177,083	177,083	5
6	V	32	Amortization of mortgage costs		Sambell of LaGrange Limited Partnership	**	1,777	1,777	6
7	V	33	Property taxes		Sambell of LaGrange Limited Partnership	**	167,510	167,510	7
8	V								8
9	V								9
10	V				** The owners of Lexington Health Care Center of LaGrange, Inc. own 100%				10
11	V				of Sambell of LaGrange Limited Partnership				11
12	V								12
13	V								13
14	Total			$ 767,510			$ 430,371	$ * (337,139)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lagrange Inc.
Provider # 0038083
1/1/03 - 12/31/03

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 190	$ 190	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	1,869	1,869	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	34	34	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	1,176	1,176	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	35	35	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	4,253	4,253	20
21	V	19	Professional fees		Royal Management Corp.	**	1,392	1,392	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	94	94	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	322	322	23
24	V	21	Bank charges		Royal Management Corp.	**	1,635	1,635	24
25	V	21	Office supplies & printing		Royal Management Corp.	**	3,735	3,735	25
26	V	21	Postage		Royal Management Corp.	**	1,680	1,680	26
27	V	21	Telephone		Royal Management Corp.	**	4,746	4,746	27
28	V	22	FICA		Royal Management Corp.	**	15,080	15,080	28
29	V	22	FUTA		Royal Management Corp.	**	271	271	29
30	V	22	SUTA		Royal Management Corp.	**	469	469	30
31	V	22	Insurance - W/C		Royal Management Corp.	**	286	286	31
32	V	22	Insurance - hospitalization		Royal Management Corp.	**	14,903	14,903	32
33	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	2,379	2,379	33
34	V	24	Travel & seminar		Royal Management Corp.	**	1,444	1,444	34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 55,993	$ * 55,993	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 4,770	$ 4,770	15
16	V	26	Insurance general		Royal Management Corp.	**	1,868	1,868	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	1,655	1,655	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	3,869	3,869	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	10,044	10,044	19
20	V	32	Interest		Royal Management Corp.	**	174	174	20
21	V	33	Property taxes		Royal Management Corp.	**	936	936	21
22	V	35	Equipment rental		Royal Management Corp.	**	2,071	2,071	22
23	V	17	Management fees	254,341	Royal Management Corp.	**		(254,341)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 254,341			$ 25,387	$ * (228,954)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	3	6.00%	Salary	$ 17,259	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	1	2.00%	Salary	10,787	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	1	2.50%	Salary	8,629	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	2.00%	Salary	2,589	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6.00%	Salary	6,580	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 45,844		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Lagrange Inc.
Provider # 0038083
1/1/03 - 12/31/03

Schedule C

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	17,021	27,234	13,617	4,085	10,383	72,340
Lexington Health Care Center of Chicago Ridge, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Elmhurst, Inc.	14,844	23,751	11,875	3,563	9,055	63,088
Lexington Health Care Center of Lake Zurich, Inc.	20,089	32,143	16,071	4,821	12,254	85,378
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Streamwood, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Wheeling, Inc.	21,870	34,993	17,496	5,249	13,342	92,950
Total	189,213	302,741	151,371	45,411	115,420	804,156

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 3,521	$	39,785	$ 190	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652		39,785	1,869	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635		39,785	34	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802		39,785	1,176	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648		39,785	35	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852		39,785	4,253	6
7	19	Professional fees	Bed Days	737,665	10	25,806		39,785	1,392	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748		39,785	94	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976		39,785	322	9
10	21	Bank charges	Bed Days	737,665	10	30,319		39,785	1,635	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243		39,785	3,735	11
12	21	Postage	Bed Days	737,665	10	31,145		39,785	1,680	12
13	21	Telephone	Bed Days	737,665	10	87,995		39,785	4,746	13
14	22	FICA	Bed Days	737,665	10	279,595		39,785	15,080	14
15	22	FUTA	Bed Days	737,665	10	5,021		39,785	271	15
16	22	SUTA	Bed Days	737,665	10	8,695		39,785	469	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294		39,785	286	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319		39,785	14,903	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113		39,785	2,379	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781		39,785	1,444	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,038,160	$		$ 55,993	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 88,444	$	39,785	$ 4,770	1
2	26	Insurance general	Bed Days	737,665	10	34,634		39,785	1,868	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679		39,785	1,655	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727		39,785	3,869	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226		39,785	10,044	5
6	32	Interest	Bed Days	737,665	10	3,219		39,785	174	6
7	33	Property taxes	Bed Days	737,665	10	17,360		39,785	936	7
8	35	Equipment rental	Bed Days	737,665	10	38,401		39,785	2,071	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 470,690	$		$ 25,387	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services II, LLC	X		Mortgage	$22,735.00	12/29/98	2,990,000	2,577,413	12/29/2008	0.0675	176,960	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank, N.A.		X	Line of Credit	Various	12/1/02	500,000		11/30/04	Prime	5,281	6
7	Partner Loans	X		Working Capital	Various	11/26/03	150,000	150,000	Demand	0.0425	123	7
8												8
9	TOTAL Facility Related				$22,735.00		$ 3,640,000	$ 2,727,413			$ 182,364	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,777	10
11								Interest income offset			(104)	11
12								Allocated from management company			174	12
13								Nonallowable partner loan interest			(123)	13
14	TOTAL Non-Facility Related						$	$			$ 1,724	14
15	TOTALS (line 9+line14)						$ 3,640,000	$ 2,727,413			$ 184,088	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 240,000	1
	Allocated from Management Company	936	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 198,271	2
3. Under or (over) accrual (line 2 minus line 1).		$ (40,793)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 210,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 7,164	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 761 For 1996 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (761)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 175,610	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	198,451	8
	1999	196,475	9
	2000	208,552	10
	2001	220,342	11
	2002	198,271	12

2002 taxes:	198,271
Estimated increase (5%):	9,914
Estimated 2003 taxes:	208,185
Use:	210,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-207-018-000	Land and building	$ 198,271.30	$ 198,271.30
2.	Royal Managament Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land and building	$ 212,239.00	$ 936.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 410,510.30	$ 199,207.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,992 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	40,000	1991	$ 500,000	1
2	Allocated from Management Company			8,605	2
3	TOTALS	40,000		$ 508,605	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 874,475	4
5	10		1995	1995	79,363	7,936	10	7,936		67,458	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20	58	58	663	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	870	11
12	Leasehold Improvements			1994	6,402	640	10	640		6,082	12
13	Leasehold Improvements - Corner Guards			1996	2,195	219	10	219		1,646	13
14	Wiring			1998	3,378	338	10	338		1,858	14
15	Resurface & Restripe Parking Lot			1998	3,753	375	10	375		2,064	15
16	Lobby Tile			1998	19,488	1,949	10	1,949		10,069	16
17	Resurface & Restripe Parking Lot			2000	1,997	200	10	200		699	17
18	Automatic Door			2000	1,300	130	10	130		455	18
19	Kitchen Rehab			2001	1,441	144	10	144		360	19
20	Infrared curtains for elevator			2001	3,000	300	10	300		750	20
21	Dining room, resident rooms, and corridors renovation			2002	150,083	7,505	20	7,505		8,129	21
22	Elevator upgrade			2002	5,399	540	10	540	0	900	22
23	Air conditioner compressor			2003	9,218	384	10	384		384	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 5,454	$	35	$ 162	$ 162	$ 1,325	37
38	Leasehold improvements - management company	1996	4,439		35	132	132	951	38
39	Leasehold improvements - management company	1989	153		31	5	5	77	39
40	HVAC - management company	1998	115		35	3	3	20	40
41	Offices - management company	1999	290		35	8	8	37	41
42	Land improvements - management company	2002	13,562		15	402	402	1,733	42
43	Building - management company	2002	105,510		40	3,130	3,130	5,056	43
44	Building improvements - management company	2003	1,046		30	27	27	27	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,085,801	$ 20,660		$ 100,711	$ 80,051	$ 988,802	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 144,929	$ 18,583	$ 19,060	$ 477	3-10 years	$ 95,459	71
72	Current Year Purchases	1,933	124	124		3-5 years	124	72
73	Fully Depreciated Assets	217,590					217,590	73
74	Allocated from Management Company	96,576		10,044	10,044		32,007	74
75	TOTALS	$ 461,028	$ 18,707	$ 29,228	$ 10,521		$ 345,180	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			16,138		1,655	1,655		12,885	79
80	TOTALS			$ 16,138	$	$ 1,655	$ 1,655		$ 12,885	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,071,572	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,367	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,594	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 92,227	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,346,867	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Bed additions	$ 141,244	92
93			93
94			94
95		$ 141,244	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,541 Description: Copier - $3,470; Allocated from Management Company - $2,071
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	3,905	$ 197,158	$	3,905	$ 197,158	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		135	9,524		135	9,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,203	252,813		4,203	252,813	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				146,407		146,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	8,243	$ 459,495	$ 146,407	8,243	$ 605,902	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 321,670	$ 326,705	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 338,394)	683,933	683,933	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,921	65,921	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	17,235	17,235	8
9	Other(specify): Escrow		134,909	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,088,759	$ 1,228,703	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,954	3,954	12
13	Land		508,605	13
14	Buildings, at Historical Cost		2,664,349	14
15	Leasehold Improvements, at Historical Cost	287,017	421,452	15
16	Equipment, at Historical Cost	149,091	477,166	16
17	Accumulated Depreciation (book methods)	(198,664)	(1,346,867)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Construction in Progress		141,244	22
23	Other(specify): Unamortized loan costs		26,648	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 241,398	$ 2,896,551	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,330,157	$ 4,125,254	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 250,553	$ 250,553	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		150,000	29
30	Accrued Salaries Payable	263,342	263,342	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,731	1,731	31
32	Accrued Real Estate Taxes(Sch.IX-B)		210,000	32
33	Accrued Interest Payable		14,498	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	69,565	64,038	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 585,191	$ 954,162	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,577,413	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,577,413	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 585,191	$ 3,531,575	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 744,966	$ 593,679	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,330,157	$ 4,125,254	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Lagrange, Inc.
Provider # 0038083
1/1/03 - 12/31/03

Schedule D

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	5,527	
Accrued management fees	21,197	21,197
Accrued 401 (k) contribution	13,319	13,319
Other accrued expenses	29,522	29,522
Total line 36	69,565	64,038

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment in Lexington Financial Services II, LLC.	222
State bedhold income	27,489
Miscellaneous income	300
Total line 28	28,011

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 723,385	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 723,385	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	739,679	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(718,100)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 21,579	17	
	B. Transfers (Itemize):			
18			18	
19	Rounding	2	19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 744,966	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,163,321	1
2	Discounts and Allowances for all Levels	(548,073)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,615,248	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	815,968	6
7	Oxygen	1,918	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 817,886	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,391	12
13	Barber and Beauty Care	23,217	13
14	Non-Patient Meals	18	14
15	Telephone, Television and Radio	12	15
16	Rental of Facility Space		16
17	Sale of Drugs	205,023	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,257	19
20	Radiology and X-Ray	6,387	20
21	Other Medical Services	100,540	21
22	Laundry	10,450	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 363,295	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	104	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 104	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule D**	28,011	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,011	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,824,544	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	922,558	31
32	Health Care	2,690,529	32
33	General Administration	1,398,109	33
	B. Capital Expense		
34	Ownership	815,628	34
	C. Ancillary Expense		
35	Special Cost Centers	198,364	35
36	Provider Participation Fee	59,677	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,084,865	40
41	**Income before Income Taxes (line 30 minus line 40)****	739,679	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 739,679	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,108	2,228	$ 89,589	$ 40.21	1
2	Assistant Director of Nursing	1,985	2,217	61,269	27.64	2
3	Registered Nurses	20,146	22,131	580,302	26.22	3
4	Licensed Practical Nurses	18,401	19,959	427,342	21.41	4
5	Nurse Aides & Orderlies	57,118	60,791	673,664	11.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,140	4,640	59,167	12.75	8
9	Activity Director	2,033	2,081	32,516	15.63	9
10	Activity Assistants	12,943	13,750	133,763	9.73	10
11	Social Service Workers	2,298	2,596	30,087	11.59	11
12	Dietician	435	459	5,514	12.01	12
13	Food Service Supervisor	2,258	2,533	44,056	17.39	13
14	Head Cook	1,170	1,205	13,680	11.35	14
15	Cook Helpers/Assistants	12,501	13,336	105,454	7.91	15
16	Dishwashers	8,771	9,264	59,229	6.39	16
17	Maintenance Workers	2,609	2,855	40,251	14.10	17
18	Housekeepers	23,681	25,683	178,751	6.96	18
19	Laundry	4,950	5,491	35,366	6.44	19
20	Administrator	1,927	2,193	96,785	44.13	20
21	Assistant Administrator					21
22	Other Administrative	348	350	45,844	130.98	22
23	Office Manager					23
24	Clerical	16,232	18,626	352,079	18.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,054	212,388	$ 3,064,708 *	$ 14.43	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	132	$ 8,149	L 1, C 3	35
36	Medical Director	12	18,000	L 9, C 3	36
37	Medical Records Consultant	9	450	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	76	3,618	L 11, C 3	44
45	Social Service Consultant	48	2,185	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	289	$ 33,602		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Morris	Administrator	0.00%	$ 96,785
John Samatas	Admin/Plant Ops	22.33%	10,787
James Samatas	Administrative	22.33%	17,259
Cynthia Thiem	Administrative	22.34%	8,629
George Samatas	Administrative	0.00%	2,589
Jason Samatas	Administrative	0.00%	6,580
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,629

B. Administrative - Other

Description	Amount
	$
Management fees (eliminated in column 7)	254,341
TOTAL (agree to Schedule V, line 17, col. 3)	$ 254,341
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ING	401 (k) administration	$ 570
Altschuler, Melvoin & Glasser LLP	Accounting	15,113
American Express Tax & Bus Srv	Accounting	5,510
Gilson, Labus & Silverman	Accounting	38
Freedman, Anselmo & Lindberg	Collections	186
Katten Muchin Zavis and Rosenman	Legal	2,436
Personnel Planners	U/C Consulting	994
James Samatas	Legal	50
Harris Kessler & Goldstein, LLC	Legal	1,039
KraKau Business	Computer Consulting	493
Carol Jeschke	Staffing Consultant	1,867
See attached Schedule F		10,154
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 38,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,932
Unemployment Compensation Insurance	44,842
FICA Taxes	219,423
Employee Health Insurance	181,080
Employee Meals	7,635
Illinois Municipal Retirement Fund (IMRF)*	
401 (k) Contributions	14,679
Other Employee Benefits	4,069
TOTAL (agree to Schedule V, line 22, col.8)	$ 486,660

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,650
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous licenses & permits	760
Miscellaneous dues & subscriptions	502
Allocated from Management Company	416
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,328

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,672
Allocated from Management Company	1,444
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,116

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lagrange, Inc.
Provider # 0038083
1/1/03 - 12/31/03

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Advanced Answers on Demand, Inc.	Computer Consulting	2,652
Action Computer Service, Inc.	Computer Consulting	346
Sachnoff & Weaver	Legal	4,164
Gigatrend	Computer Consulting	195
Information Controls, Inc.	Computer Consulting	867
eHealth Solutions	Computer Consulting	1,080
Nyemaster, Goode, Voigts, West, Hansell & O'Brien	Legal	850
Total, Other Professional Services		10,154
Total, Agrees to Schedule V, Line 19, Column 3		38,450
Allocated from management co.		
American Express Tax & Business Services	Accounting	303
Gilson, Labus and Silverman	Accounting	28
James Samatas	Legal	37
Katten, Muchin, Zavis and Rosenman	Legal	35
Sachnoff and Weaver	Legal	276
ING / Pension Administrators	401 (k) Administration	372
Personnel Planners	U/C Consulting	13
Various	Consulting	328
Various	Computer Consulting	4,253
Allocated from building partnership		
James Samatas	Filing and recording fees	68
JSO Valuation Group, Ltd.	Appraisal	3,500
Dennis W. Hetler & Associates PC	Real Estate Tax appeal	3,664
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(186)
Disallow out of period legal fees		
Katten, Muchin, Zavis & Rosenman	Legal - out of period	(286)
Reclassifications		
Dennis W. Hetler & Associates PC	Real Estate Tax appeal	(3,664)
JSO Valuation Group, Ltd.	Appraisal	(3,500)
Total, Agrees to Schedule V, Line 19, Column 8		43,691

See accountants' compilation report.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	Various 2000	$ 1,428	3 years	$ 238	$ 476	$ 476	$ 238	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,428		$ 238	$ 476	$ 476	$ 238	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **4 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,438** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,677**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,635** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **18**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of LaGrange** **12:22 PM 11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	Explanation	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-549,447	equal to	-549,447	0	O.K.		Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	184,088	equal to	184,088	0	O.K.		Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	175,610	equal to	175,610	0	O.K.		Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!		Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	131,594	equal to	131,594	0	O.K.		Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.		Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	5,541	equal to	5,541	0	O.K.		Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.		Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.		Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	459,495	equal to	459,495	0	O.K.		Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	146,407	equal to	#VALUE!	#VALUE!	#VALUE!		Pg16 V32	N/A	14	6	Pg4 F22 + Pg	N/A	39,10a	2
Income Stat. General Serv.	922,558	equal to	922,558	0	O.K.		Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,690,529	equal to	2,690,529	0	O.K.		Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,398,109	equal to	1,398,109	0	O.K.		Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	815,628	equal to	815,628	0	O.K.		Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	198,364	equal to	198,364	0	O.K.		Pg19 P17	N/A	35	2	Pg4 H21..H2	N/A	38to41+43	4
Income Stat. Prov. Partic.	59,677	equal to	59,677	0	O.K.		Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,832,166	equal to	1,891,333	-59,167	FAILED		Pg20 K11..K15+I	A.	5,24,25,27-3	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.		Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.		Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	166,279	equal to	166,279	0	O.K.		Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	30,087	equal to	30,087	0	O.K.		Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	227,933	equal to	227,933	0	O.K.		Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	40,251	equal to	40,251	0	O.K.		Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	178,751	equal to	178,751	0	O.K.		Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	35,366	equal to	35,366	0	O.K.		Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	142,629	equal to	142,629	0	O.K.		Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	352,079	equal to	352,079	0	O.K.		Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.		Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,064,708	equal to	3,064,708	0	O.K.		Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,149	< or = to	8,149	0	O.K.		Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	18,000	< or = to	18,000	0	O.K.		Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,650	< or = to	11,094	-9,444	O.K.	ok, Medical waste included	Pg20 X14..X16	B. & C.	o39 and 50t	2	Pg3 G19	N/A	10	3
Activity Consultant	3,618	< or = to	3,618	0	O.K.		Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,185	< or = to	2,185	0	O.K.		Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	142,629	equal to	142,629	0	O.K.		Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	254,341	equal to	254,341	0	O.K.		Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	38,450	equal to	38,450	0	O.K.		Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Professional Fees - pg.6, column B/Sch	43,691	equal to	43,691	0	good to go									
Supp. Sched.- Benefit/Taxes	486,660	equal to	486,660	0	O.K.		Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	11,328	equal to	11,328	0	O.K.		Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,116	equal to	5,116	0	O.K.		Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	59,677	equal to	59,677	0	O.K.		Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	7,635	< or = to	41,023	-33,388	O.K.	ok	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	7,635	equal to	7,635	0	O.K.		Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.		Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,673	equal to	6,138	-465	FAILED	ok, 5,673 medicare days	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-510,100	equal to	-510,100	0	O.K.		Pg5 Z18	B.	34	1	Pg6 to Pg 6I	B.	14	8
Total loan balance	2,727,413	equal to	2,727,413	0	O.K.		Pg9 L34	A.	15	7	Pg17 V13+V2	N/A	29+39-41	2
Real estate tax accrual	210,000	equal to	210,000	0	O.K.		Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	508,605	equal to	508,605	0	O.K.		Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,085,801	equal to	3,085,801	0	O.K.		Pg12 to 12I L4	B.	36	4	Pg17 K26+K2	N/A	14 & 15	2
Equipment and vehicle cost	477,166	equal to	477,166	0	O.K.		Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,346,867	equal to	1,346,867	0	O.K.		Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	744,966	equal to	744,966	0	O.K.		Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	739,679	equal to	739,679	0	O.K.		Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.		Pg22 F31-J31..	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,330,157	equal to	1,330,157	0	O.K.		Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**					
	TO THE COST REPORT!!	11/4/2005		12:22:13 PM		
HSA Number	?	Name	Lexington of LaGrange			
Cost report period	From:	01/01/03	To:	12/31/03	Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N				
Licensed bed days:	39,785	Occupancy:	38,513	Pct. of occupancy:	96.80%	
Illinois Public Aid Support Rate		$				

Genl Services Salary/Wage:	482,301	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage	494,708	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage	3,064,708	Col 1, Line 44 ---Audit Adj:	
Employee Benefits	486,660	Col 8, Line 22 ---Audit Adj:	
Total General Services:	907,997	Col 8, Line 8 ---Audit Adj:	
Total General Admin	1,209,611	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amour by this proportion to get the fringe amoun for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$482,301
Divided by Total Wages (Column 1, Line 44	$3,064,708
General service wages as percent of total wages	15.7373%
Employee Benefits (Column 10, Line 22	$486,660
Allocation of Employee Benefits to General Services Costs	$76,587
Plus Total General Services (Column 10, Line 8	$907,997
New Total General Services Cost	$984,584

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$494,708
Divided by Total Wages (Column 1, Line 45	$3,064,708
General administration wages as a percent of total wages	16.1421%
Employee Benefits (Column 10, Line 22	$486,660
Allocation of Emplayee Benefits to General Admin. Cost	$78,557
Plus Total General Administration (Column 10, Line 2	$1,209,611
Minus Total Fringe (Column 10, Line 22	$486,660
New Total General Administration Cos	$801,508

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflatior fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$984,584	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$984,584

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$801,508	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$801,508
3 Total Updated Support Costs (1 + 2		$1,786,092

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $46.38

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$1,786,092
Total Patient Days (Cost Report	38,513
Support Costs per Diem	$46.38

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	39,785
Multiplied by	0.93
	37,000
Minus total Patient Days	38,513
	-1,513
One-third of difference	-504
Plus Total Patient Day	38,513
Adjusted Occupancy	38,009
Total Support Costs (Step II, C, 3, above	$1,786,092
Divided by Adjusted Occupany	38009
Support Costs Per Diem	$46.99

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75t percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to o greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$46.38
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Dier	$46.38
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listec in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$46.38
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II anc	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Dier	$46.38
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 12:22:13 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Lexington of LaGrange** ID: **0038083**

HSA No.: ? Own or Rent? (O or R) ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	109	Total Patient Days	38,513
Begin	01/01/03	Licensed Bed Days:	39,785	% Occupied	96.80%
End	12/31/03			Capital Days	38,513

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1993
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	3085801
2. Total licensed beds from cost report Page 2, Line 7, column 3	109
3. Line 1 divided by Line 2	$28,310
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	38,513
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	38,513
2. Total Licensed Bed Days * .93	37000
3. Capital Days (higher of Line 1 or Line 2)	38,513

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	92	2661448	244853216	12	97	0	0	0	12B
2	2	95	79363	7539485	12	98	0	0	0	12B
3	3	0	0	0	12	99	0	0	0	12C
4	4	0	0	0	12	100	0	0	0	12C
5	5	0	0	0	12	101	0	0	0	12C
6	6	92	1152	105984	12	102	0	0	0	12C
7	7	92	2714	249688	12	103	0	0	0	12C
8	8	93	2901	269793	12	104	0	0	0	12C
9	9	94	6402	601788	12	105	0	0	0	12C
10	10	96	2195	210720	12	106	0	0	0	12C
11	11	98	3378	331044	12	107	0	0	0	12C
12	12	98	3753	367794	12	108	0	0	0	12C
13	13	98	19488	1909824	12	109	0	0	0	12C
14	14	100	1997	199700	12	110	0	0	0	12C
15	15	100	1300	130000	12	111	0	0	0	12C
16	16	101	1441	145541	12	112	0	0	0	12C
17	17	101	3000	303000	12	113	0	0	0	12C
18	18	102	150083	15308466	12	114	0	0	0	12C
19	19	102	5399	550698	12	115	0	0	0	12C
20	20	103	9218	949454	12	116	0	0	0	12C
21	21	0	0	0	12	117	0	0	0	12C
22	22	0	0	0	12	118	0	0	0	12C
23	23	0	0	0	12	119	0	0	0	12C
24	24	0	0	0	12	120	0	0	0	12C
25	25	0	0	0	12	121	0	0	0	12C
26	26	0	0	0	12	122	0	0	0	12C
27	27	0	0	0	12	123	0	0	0	12C
28	28	0	0	0	12	124	0	0	0	12C
29	29	0	0	0	12	125	0	0	0	12C
30	30	0	0	0	12	126	0	0	0	12C
31	31	0	0	0	12	127	0	0	0	12C
32	32	0	0	0	12	128	0	0	0	12C
33	33	0	0	0	12	129	0	0	0	12C
34	34	95	5454	518130	12A	130	0	0	0	12C
35	35	96	4439	426144	12A	131	0	0	0	12D
36	36	89	153	13617	12A	132	0	0	0	12D
37	37	98	115	11270	12A	133	0	0	0	12D
38	38	99	290	28710	12A	134	0	0	0	12D
39	39	102	13562	1383324	12A	135	0	0	0	12D
40	40	102	105510	10762020	12A	136	0	0	0	12D
41	41	103	1046	107738	12A	137	0	0	0	12D
42	42	0	0	0	12A	138	0	0	0	12D
43	43	0	0	0	12A	139	0	0	0	12D
44	44	0	0	0	12A	140	0	0	0	12D
45	45	0	0	0	12A	141	0	0	0	12D
46	46	0	0	0	12A	142	0	0	0	12D
47	47	0	0	0	12A	143	0	0	0	12D
48	48	0	0	0	12A	144	0	0	0	12D
49	49	0	0	0	12A	145	0	0	0	12D
50	50	0	0	0	12A	146	0	0	0	12D
51	51	0	0	0	12A	147	0	0	0	12D
52	52	0	0	0	12A	148	0	0	0	12D
53	53	0	0	0	12A	149	0	0	0	12D
54	54	0	0	0	12A	150	0	0	0	12D
55	55	0	0	0	12A	151	0	0	0	12D
56	56	0	0	0	12A	152	0	0	0	12D
57	57	0	0	0	12A	153	0	0	0	12D
58	58	0	0	0	12A	154	0	0	0	12D
59	59	0	0	0	12A	155	0	0	0	12D
60	60	0	0	0	12A	156	0	0	0	12D
61	61	0	0	0	12A	157	0	0	0	12D
62	62	0	0	0	12A	158	0	0	0	12D
63	63	0	0	0	12A	159	0	0	0	12D
64	64	0	0	0	12A	160	0	0	0	12D
65	65	0	0	0	12A	161	0	0	0	12D
66	66	0	0	0	12A	162	0	0	0	12D
67	67	0	0	0	12B					
68	68	0	0	0	12B					
69	69	0	0	0	12B					
70	70	0	0	0	12B					
71	71	0	0	0	12B					
72	72	0	0	0	12B					
73	73	0	0	0	12B					
74	74	0	0	0	12B					
75	75	0	0	0	12B					
76	76	0	0	0	12B					
77	77	0	0	0	12B					
78	78	0	0	0	12B					
79	79	0	0	0	12B					
80	80	0	0	0	12B					
81	81	0	0	0	12B					
82	82	0	0	0	12B					
83	83	0	0	0	12B					
84	84	0	0	0	12B					
85	85	0	0	0	12B					
86	86	0	0	0	12B					
87	87	0	0	0	12B					
88	88	0	0	0	12B					
89	89	0	0	0	12B					
90	90	0	0	0	12B					
91	91	0	0	0	12B					
92	92	0	0	0	12B					
93	93	0	0	0	12B					
94	94	0	0	0	12B					
95	95	0	0	0	12B					
96	96	0	0	0	12B					

Base year:
Total of Column C/Total of Column B = Base Year

287277148 3085801 93.09645956

Base Year = 1993

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	227,933	17,647	8,149	253,729	0	253,729	0	253,729
2. Food Purchase	0	156,568	0	156,568	0	156,568	-7,653	148,915
3. Housekeeping	178,751	18,833	0	197,584	0	197,584	190	197,774
4. Laundry	35,366	11,506	0	46,872	0	46,872	-10,450	36,422
5. Heat and Other Utilities	0	0	131,741	131,741	0	131,741	1,903	133,644
6. Maintenance	40,251	0	95,813	136,064	0	136,064	1,449	137,513
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	482,301	204,554	235,703	922,558	0	922,558	-14,561	907,997
9. Medical Director	0	0	18,000	18,000	0	18,000	0	18,000
10. Nursing & Medical Records	1,891,333	97,983	11,094	2,000,410	0	2,000,410	0	2,000,410
10a. Therapy	0	0	459,495	459,495	0	459,495	0	459,495
11. Activities	166,279	10,455	3,618	180,352	0	180,352	0	180,352
12. Social Services	30,087	0	2,185	32,272	0	32,272	0	32,272
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,087,699	108,438	494,392	2,690,529	0	2,690,529	0	2,690,529
17. Administrative	142,629	0	254,341	396,970	0	396,970	-254,341	142,629
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	38,450	38,450	0	38,450	5,241	43,691
20. Fees, Subscriptions & Promotion	0	0	11,437	11,437	0	11,437	-109	11,328
21. Clerical & General Office	352,079	25,339	15,754	393,172	0	393,172	11,606	404,778
22. Employee Benefits & Payroll	0	0	445,637	445,637	0	445,637	41,023	486,660
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,672	3,672	0	3,672	1,444	5,116
25. Other Admin. Staff Trans	0	0	0	0	0	0	4,770	4,770
26. Insurance-Prop.Liab.Malpractice	0	0	108,771	108,771	0	108,771	1,868	110,639
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	494,708	25,339	878,062	1,398,109	0	1,398,109	-188,498	1,209,611
29. Total General Administrative	3,064,708	338,331	1,608,157	5,011,196	0	5,011,196	-203,059	4,808,137
30. Depreciation	0	0	39,367	39,367	0	39,367	92,227	131,594
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	5,281	5,281	0	5,281	178,807	184,088
33. Real Estate	0	0	0	0	0	0	175,610	175,610
34. Rent - Facility & Grounds	0	0	767,510	767,510	0	767,510	-767,510	0
35. Rent - Equipment & Vehicles	0	0	3,470	3,470	0	3,470	2,071	5,541
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	815,628	815,628	0	815,628	-318,795	496,833
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	146,407	0	146,407	0	146,407	0	146,407
40. Barber and Beauty Shop	0	0	20,534	20,534	0	20,534	0	20,534
41. Coffee and Gift Shops	0	0	3,830	3,830	0	3,830	0	3,830
42. Provider Participation	0	0	59,677	59,677	0	59,677	0	59,677
43. Other (specify):*	0	0	27,593	27,593	0	27,593	-27,593	0
44. Total Special Cost Ce	0	146,407	111,634	258,041	0	258,041	-27,593	230,448
45. Grand Total	3,064,708	484,738	2,535,419	6,084,865	0	6,084,865	-549,447	5,535,418

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	321,670	326,705
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	683,933	683,933
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	65,921	65,921
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	17,235	17,235
9. Other (specify):	0	134,909
10. Total current assets	1,088,759	1,228,703
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	3,954	3,954
13. Land	0	508,605
14. Buildings, at Historical Cost	0	2,664,349
15. Leasehold Improvements, Historical Cost	287,017	421,452
16. Equipment, at Historical Cost	149,091	477,166
17. Accumulated Depreciation (book methods)	-198,664	-1,346,867
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	141,244
23. other (specify):	0	26,648
24. Total Long-Term Assets	241,398	2,896,551
25. Total Assets	1,330,157	4,125,254
CURRENT LIABILITIES		
26. Accounts Payable	250,553	250,553
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	150,000
30. Accrued Salaries Payable	263,342	263,342
31. Accrued Taxes Payable	1,731	1,731
32. Accrued Real Estate Taxes	0	210,000
33. Accrued Interest Payable	0	14,498
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	69,565	64,038
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	585,191	954,162
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,577,413
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	2,577,413
46.Total Liabilities	585,191	3,531,575
47.Total Equity	744,966	593,679
48.Total Liabilities and Equity	1,330,157	4,125,254

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,163,321
2. Discounts and Allowances for all Levels	-548,073
Subtotal - Inpatient Care	5,615,248
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	815,968
7. Oxygen	1,918
Subtotal - Anciliary Revenue	817,886
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	3,391
13. Barber and Beauty Care	23,217
14. Non-Patient Meals	18
15. Telephone, Television, and Radio	12
16. Rental of Facility Space	0
17. Sale of Drugs	205,023
18. Sale of Supplies to Non-Patients	0
19. Laboratory	14,257
20. Radiologyand X-Ray	6,387
21. Other Medical Services	100,540
22. Laundry	10,450
Subtotal - Other Operating Revenue	363,295
24. Contributions	0
25. Interest and Other Investments Income	104
Subtotal - Non-Operating Revenue	104
27. Other Revenue (specify):	28,011
28. Other Revenue (specify):	0
Subtotal - Other Revenue	28,011
30. Total Revenue	6,824,544
31. General Services	922,558
32. Health Care	2,690,529
33. General Administration	1,398,109
34. Ownership	815,628
35. Special Cost Centers	198,364
35. Provider Participation Fee	59,677
37. Other	0
40. Total Expenses	6,084,865
41. Income Before Income Taxes	739,679
42. Income Taxes	0
43. Net Income or Loss for the Year	739,679

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23	Provider Participation fee is linked from page 4